Minimum Standards for ICO Phase One Applications

Complete and Timely Applications

- Late applications will not be approved to proceed to Phase Two.
- Incomplete applications will not be approved to proceed to Phase Two. The organization must provide a response to each Phase One (not italicized) item in the application.
    - Unless indicated otherwise for key sections below, responses may indicate that additional detail is being developed and will be provided in subsequent phases; this will not be considered missing or skipping a requirement.
- If an organization meets the minimum standards but additional detail on or revisions to some components of Phase One requirements are needed, these items may be added to Phase Two documentation requirements.
- If an organization does not meet the minimum standards in Phase One, it will not be approved to proceed to Phase Two.

Chapter 1 (General Information)

- The organization must have capacity in *every* type of care listed: medical, long term, palliative, and mental/behavioral health. Capacity may be internal or via contracted providers, and a plan to subcontract is sufficient (contracts do not have to be signed at the time of application), but failing to obtain or plan for capacity in any type of care will disqualify an organization.
- The organization must have some experience with the Medicare *and/or* Medicaid populations in its current operations.
- The organization may not have any sanctions, penalties, or corrective action plans that would make them ineligible to receive passive enrollments as determined by CMS.
- The organization must be able to document some legal entity status (articles of incorporation, bylaws, or other documentation).
- The organization must describe its business model and include the relationship with nursing homes. This is a key section, and the described organizational chart details must be provided in the initial application.

Chapter 2 (Administration)

- Personnel qualifications and position descriptions for key financial positions demonstrate sufficient experience and staff capacity to fulfill financial reporting obligations

Chapter 3 (Financial)

- Licensed HMO in the State of Wisconsin
- Attestation and/or documentation with regulatory bodies (CMS, DHS, and OCI) is provided, and is corroborated by each agency.
- Audit reports and financial statements show sufficient capitalization to bear the risk associated with a new pilot program.
- A complete response to each part of Chapter 3, Section I (Fiscal Soundness) is required. This is a key section, and this level of detail must be provided in the initial application.

Chapter 4 (Marketing): No minimums beyond providing a response to each item.

Chapter 5 (Required Services)

- The required services table must include each service in the benefit package. This is a key section, and this level of detail must be provided in the initial application.
- The IDT description must include each bulleted sub-item under IV.A. While details may subsequently be revised, some description, evidence, example, or plan (as requested in the application) must be provided for each item. This is a key section, and this level of detail must be provided in the initial application.
- The timeframe for assessments must be identified in section V. Requirements for specific timeframes are not being established by DHS, but the organization must have some standard of its own for assessment timeframes. This is a key section, and this level of detail must be provided in the initial application.
- The Plan of Care description must include each lettered item under VII. While details may subsequently be revised, some description, evidence, example, or plan (as requested in the application) must be provided for each item. This is a key section, and this level of detail must be provided in the initial application.

Chapter 6 (Participant Rights)

- The description of how the organization will support enrollee rights in I.A. is a key section; examples must be provided as requested, and this level of detail must be provided in the initial application.
- Policy & procedure on restraints in II.A. is a key section, and each element in the bulleted list must be addressed; this level of detail must be provided in the initial application.

Chapter 7 (Quality)

- The organization must have some prior experience with quality assurance and performance improvement.
- In Section II.A., the organization's methodology description must include each of the five areas for performance improvement. The methodology may be preliminary, but the organization must outline a potential methodology for each area. This is a key section, and this level of detail must be provided in the initial application.
- The organization must have a health care data system to collect data. No specific type of system or format is required at this time, but there must be some system in place for data collections.

Chapters 8 (Enrollment), 9 (Payment), & 10 (Data): No minimums beyond providing a response to each item. Requirements are not well-developed enough here to establish minimum standards.

Chapter 11 (Part D)

- The ICO does not mark "No" on any of the required attestations. This requirement may only be waived with CMS approval.